REPORT OF JOB PLACEMENT
IMPACT Service Provider

State Form 47579 (9-96) / IMP 0013

Name of Service Provider	Agreement number	County
Name of Contact	Telephone number of Contact	Date *(month, year)*

A/F PROGRAM	* TYPE	NAME OF CLIENT	SOCIAL SECURITY NUMBER	NAME OF EMPLOYER	POSITION	DATE BEGAN	WAGE PER HOUR	HEALTH BENEFITS	
								Available	Accepted
								☐ Yes ☐ No	☐ Yes ☐ No
								☐ Yes ☐ No	☐ Yes ☐ No
								☐ Yes ☐ No	☐ Yes ☐ No
								☐ Yes ☐ No	☐ Yes ☐ No
								☐ Yes ☐ No	☐ Yes ☐ No
								☐ Yes ☐ No	☐ Yes ☐ No
								☐ Yes ☐ No	☐ Yes ☐ No
								☐ Yes ☐ No	☐ Yes ☐ No
								☐ Yes ☐ No	☐ Yes ☐ No
								☐ Yes ☐ No	☐ Yes ☐ No
								☐ Yes ☐ No	☐ Yes ☐ No
								☐ Yes ☐ No	☐ Yes ☐ No
								☐ Yes ☐ No	☐ Yes ☐ No

*** TYPE:** **P =** Placement / IMPACT Standard; **O =** OJT; **I =** Interim Employment; **G =** Grant Diversion